Changing Childbirth Customs

Author: Chalmers, Beverley

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Full Text: Headnote ABSTRACT: The meaning and usefulness of the concept of cross-cultural childbirth is questioned in this paper. Intracultural variations within Southern African Black women's experiences of childbirth are utilized to explore the validity of the cross-cultural concept. The question of universality or diversity of birth experiences is discussed. Possible universal elements of birth are suggested while factors determining variations in these experiences are proposed. In Southern Africa, traditional views of health and illness co-exist with those of Western medicine. Empirical Western medicine, on the one hand, has been concerned largely with the observation and manipulation of aetiological factors. By contrast traditional Black views of illness are contextualized in an holistic framework. Not only are psychosocial or physical aspects of the world seen as influencing health but so too are spiritual or magical elements. These philosophies influence the experience of childbirth. In essence, traditional Black birth incorporates delivering at home, assisted by older women experienced in childbirth; the Western approach involves hospital or clinic delivery aided by standard medical technology. Black women in Southern Africa may experience either or both of these approaches. Such details about traditional birth practices in various tribal groups as are available (1, 2, 3, 4) suggest that pregnancy and birth are characterized by: secrecy about pregnancy; the use of isihlambezo (a herbal mixture) to facilitate delivery; birth in an upright or squatting position; the presence of a traditional birth attendant and trusted close family members; burial of the placenta, membranes and blood lost during birth; and the exclusion of the husband from all events surrounding birth. Post-partum, the mother is kept in seclusion with her infant and a close family member who instructs her about infant care. Babies are customarily breast fed, but colostrum is generally viewed with disfavour, and discarded. Little is known about how traditional birth practices have been modified in the process of moving towards first world medical systems. While rural births continue to take place, more and more Black women are giving birth in hospitals and clinics in both urban and rural environments (1). Consequently, it was deemed useful to explore the experiences, attitudes, beliefs and knowledge of pregnancy, birth and the post-partum period in Pedi women delivering in both urban and rural environments. PROCEDURE In all 171 Pedi women were interviewed either ante-natally (n=89) or post-natally (n=82). Of these, 45 delivered in urban hospitals and 42 in rural clinics; a further 37 delivered in rural hospitals and 47 in rural clinics. The average age of the sample was 27.6 years (range 16-44) with the mean number of children per woman being 1.75 (range 0-10). A little over half the women (58.5%) were married while as many as 39.7% were single and 1.8% divorced. The average educational level attained by the women was 8 years of schooling (range 0-12). Interviews were conducted by one of two retired midwives from Baragwanath Hospital (a large provincial hospital on the outskirts of Johannesburg), each with more than 20 years of experience in midwifery. These were based on either an ante-natal or a post-natal interview schedule. Each interview schedule contained approximately 170 questions and interviews took between 1.5-2.5 hours to complete. Interviews were taped whenever possible and tapes were checked against completed interview schedules by an independent Northern Sotho (Pedi) speaking graduate. The error rate reflecting errors of translation, transcription or interpretation was 0.73%. RESULTS Statistical comparisons between women delivering in hospital and clinics revealed no significant differences on any of the variables examined. In addition, as very few statistically significant differences between urban and rural women were found, results for the whole sample are presented here. Urban-rural differences are specified where they occur. Current practices are contrasted with traditional views regarding conception, and some ante-natal, delivery and post-natal customs. Conception As can be seen from

Table 1, detection of pregnancy occurs earlier today (+ - 2.1 months) than traditionally (between 4-6 months) (3) but is still kept a secret from most others, including close family members. Husbands are, however, always told about a pregnancy. The signs of conception are similar to "Western" ones: cessation of menstruation (regarded by 96.6% as a sign of pregnancy), enlarged abdomen (96.6%), breast changes (85.4%), medical confirmation (78.7%), tiredness (77.5%), and nausea (60.7%). However, a little over half the sample (52.8%) still rely on dreams to indicate a conception. Traditionally, dream content indicative of a pregnancy included dreams of water, of round gourds, of young growing corn, of pregnancy or of being informed of the pregnancy by ancestral spirits or by a "sangoma" (spiritual healer) in a dream (1). In the 52.8% of women studied who did report relying on dreams as indications of conception, the most frequently reported dream was of pregnancy (36%). Dreams of baby care (11.2%), of snakes (4.5%) or of being informed by a sangoma of the pregnancy (1.1%) were also reported.

Table 1
Results: Conception

Traditional	*Current*
• Knowledge of pregnancy at 4–6 months	• Knowledge of pregnancy at 2.1 months
• Secrecy	• 29.2% tell mother 22.5% tell other family 7.9% tell friends

Mothers were also questioned about their knowledge of when conception can occur. Table 2 reveals that a third to almost a half of the sample are not sure of the correct answer. In general Table 2 reveals a poor understanding of the timing of conception. Ante-Natal Customs A second major area of the study concerned ante-natal customs. Table 3 contrasts some traditional customs with current practices. It appears, from Table 3, that knowledge about pregnancy and childbirth is currently being sought from sources other than traditional ones. The high proportion of ante-natal clinic attenders reflected in Table 3 is probably not indicative of clinic attendance amongst all Black women: the present sample was drawn from clinic attenders which may be responsible for the high clinic attendance rate reflected.

Table 2
When Conception Occurs (Ante-Natal Sample N = 89)

When can you conceive?	*Yes*	*No*	*Don't know*
While bleeding	10.1	53.9	36.0
Anytime you're not bleeding	39.3	27.0	33.7
Two weeks before bleeding	28.1	25.8	46.1
Two weeks after bleeding	32.6	24.7	42.7

Table 3
Results: Ante-Natal Customs

Traditional	*Current*
• Sources of information *traditional teacher *mother *observation	• Sources of information *nurses (39.3%) *experience (34.9%) *reading (34.2%) *mother (7.8%)
• Pregnancy care–informal	• 96.4% attendance at ANC
• Use 'isihlambezo'	• 1.1% use 'isihlambezo'

Knowledge about some aspects of pregnancy was explored in the ante-natal sample. For instance, 43% of women were unaware of the functions of the placenta, 70% were unsure of the amniotic fluid's functions and 84% were unaware of the meaning of'intact' membranes at delivery. Traditional explanations were given by some women for these functions. For instance 42% described the placenta as the baby's blanket, 11% as the baby's cradle, while only 5% thought the placenta was involved in feeding the baby. The amniotic fluid was described as 'opening the way for the baby' by 19%, while only 9% thought it served a protective function. The traditional meaning of a "lucky" or blessed baby was ascribed to the baby born with intact membranes by 16%. In general it appears that knowledge of both traditional meanings and Western understanding of these aspects of pregnancy and birth is limited. Delivery Knowledge of Western birthing techniques is also very limited (Table 4). Table 4 suggests that despite the high proportion of the sample who attended ante-natal clinics (where some childbirth preparation is conducted) most women are ignorant of Western birthing technology. Women also seem to be unaware of such traditionally crucial customs (1) as burial of the placenta, membranes and blood lost during childbirth (Table 4). It is ironic that "Western" medicine is closely rejecting the supine position preferred for delivery in favour of a more upright or even squatting position while the Black woman appears to be progressing in the opposite direction! (Table 4). When asked why the supine position is preferred for delivery most of the sample reply "because that is what the nurses tell us is best', or "because it's easier for the doctor'.

Table 4
Results: Delivery Customs

Traditional	*Current*
• Knowledge of birth from observation	• Knowledge of birth 73% unaware of episiotomy 75.3% unaware of C/S 86.5% unaware of forceps 96.6% unaware of induction 96.6% unaware of vacuum extraction
• Burial of placenta, blood	• Awareness of burial custom in 3.6%
• Upright position	• Supine position preferred by 92.5%

Issues surrounding delivery were explored further. Differences in the preferred delivering assistant amongst urban and rural women can be seen in Table 5. In the urban situation 'Western' practices appear almost totally acceptable. However, amongst the rural women a clear preference for delivery by a black midwife rather than any other category of medical professional is evident. However, no women in either group wanted to be attended by a traditional birth attendant for delivery. This rejection of the traditional birth attendant for delivery also extended to her role as a social support during delivery. Interestingly only 1.2% of the women would have liked their mothers (Footnote 1) with them at delivery while 2.4% would have valued their husband's presence. After birth 19.5% of the women wanted their mothers present and 30.5% their husbands. Social support desired in the post-partum period varies according to the time period studied. In the first few hours after delivery the doctor's/nurse's presence is most desired (by 42.7% of women), then the husband's (30.5%) and lastly the mother's (19.5%). In the days after delivery the order is reversed, with the mother being needed by 62.2%, the husband by 24.4% and the doctor/nurse by 8.5% of women. No women wished to have their mothers-in-law or the traditional birth attendant present in the hours after birth while only 1.2% of women wished to have their mothers-in-law present in the days after birth. It appears that the persons needed most at the different post-partum times reflect the need for different kinds of support at these times-physical, emotional or practical.

Table 5
Urban-Rural Differences Regarding Preferred Delivery Assistant

Preferred Assistant	*Urban %*	*Rural %*	*x*
White male doctor	97.8	29.8	$p < .001$
Black male doctor	97.8	29.4	$p < .001$
White female doctor	97.8	36.4	$p < .001$
Black female doctor	97.8	34.1	$p < .001$
White midwife	97.8	18.9	$p < .001$
Black midwife	100.00	70.5	$p < .001$
Traditional birth attendant	0	0	

In some tribal groups it is customary for the mother-in-law to assist at delivery, e.g., the Zulu. In others such as the Pedi women of this sample the mother is the traditional delivery assistant at least for the first pregnancy.

The types of support provided are also reflected in Tables 6 and 7. Table 6 reflects the expected source of support in the post-partum period while Table 7 reflects the types of support given. Table 6 reveals that mothers and nurses are predominantly looked to for help. Table 7 shows that husbands do not given much assistance after delivery except for some financial and emotional help. Mothers bear the brunt of the practical and even emotional support needs of the mother in the post-partum period.

Table 6
Help Expected Post-Partum (Ante-Natal Sample N = 89)

Who Will Help?	*%*
Mother	62.9
Nurses	51.7
Mother-in-law	25.8
Husband	22.5
No-one	20.2
Friends	2.3
Traditional midwife	0

Table 7
Types of Support Post-Partum (Post-Partum Sample N = 82)

Type of support	*Husband*	*Mother*	*Family*	*No help*
Nappies	–	40.2	12.2	23.2
Day feeds	–	15.9	7.3	51.2
Bath time	–	35.4	12.2	25.6
Other children	–	23.2	19.5	11.0
House keeping	1.2	19.5	26.8	13.4
Other family	2.4	23.2	32.9	12.2
Emotional	23.2	29.3	15.9	3.7
Financial	48.8	20.7	7.3	–

Infant Feeding The final area of study examined in the present study concerns infant feeding. Women were asked about their intentions regarding feeding method (ante-natal sample) and their actual practice (post-partum sample). While 67.1% of ante-natal women intended to breast feed, 70.7% of the post-partum sample did so. Mixed feeding was intended by 21.6% of ante-natal women and practiced by 24.4% of post-partum women. Bottle only was intended as an infant feeding method by 11.4% of the ante-natal sample and practiced by 3.7% of the post-partum women. The intended length of breast feeding of the sample suggested that most

women intended to breast feed for up to two years (Table 8). Whether actual behaviour will correspond with intentions, however, requires further study. Sources of advice on infant feeding methods were also explored (Table 9). Table 9 reveals that doctors give very little advice or information about any form of feeding method to mothers. Nurses and clinics are prime sources of such advice. However Table 9 reveals that relatively few women receive advice about either method of feeding.

Table 8
Intended Length of Breast Feeding

Time Period	*Ante-Natals*	*Post-Natals*
Up to 1 month	0	0
Up to 6 months	8.0	79.8
Up to 1 year	27.3	19.5
Up to 2 years	47.7	56.1
More than 2 years	3.4	35.4

Table 9
Sources of Advice on Infant Feeding Methods
(Post-Partum Sample N = 82)

Source of advice	*On breast feeding*	*On bottle feeding*	*On both*
Doctor	1.2	0	0
Nurses	32.9	6.1	20.7
Clinics	14.6	2.4	15.9
Woman's mother	8.5	1.2	0
Woman's sister(s)	2.4	1.2	2.4

Beliefs about breast feeding in the women studied revealed generally positive views towards breast feeding. For instance most women believed that breast is best (96.3%); that breast feeding calms the baby (95.1%); makes it easier to love the baby (93.9%); leads to a healthier baby (82.9%), and helps teething (46.3%). A large number of women (67.1%) believed too that breast feeding improves the baby's character. This view probably stems from a traditional belief that bottle fed babies are those that eventually develop into the 'tsotsies' (delinquents) of the society. Research into this aspect of the study revealed some of the difficulties associated with cross-cultural research. The importance of not allowing the viewpoint of the researcher to cloud the question asked was clearly revealed by enquiries about drooping breasts following breast feeding. For instance, when asked if breast feeding results in sagging breasts 87.8% answered 'yes' which answer is possibly similar to current Western stereotyped beliefs (5). However, when asked if sagging breasts are desirable, 37.8% of the women also said 'yes', in contrast to stereotyped Western views. This potential research pitfall was also clearly illustrated when inquiring about the value of colostrum. Traditionally colostrum is regarded as bad for the baby and discarded (1). Ante-natal clinics devote time to trying to change this culturally traditional approach. When the present sample were asked whether colostrum was good for the baby an encouraging 62.2% answered in the affirmative. However, when asked whether water was better for the baby than colostrum, 81.7% replied in the affirmative. Even formula milk was seen as preferable to colostrum by 46.3% of the sample. The overall picture presented by the results is that of a culture that is rapidly moving from traditional childbirth practices to first world medical approaches. Some of this movement can be more clearly seen by an examination of urban-rural differences (Table 10). Table 10 indicates those factors in which a statistically significant difference between urban and rural mothers was found. Rural mothers tended to adhere more strongly to beliefs in the special qualities of the blood lost in birthing; to beliefs in the current practice of witchcraft, even in hospitals and clinics; that pain should not be expressed in labour as is the traditional custom; that husbands should be excluded from the post-partum period as well as from delivery; that colostrum is bad for the baby; that sagging breasts are desirable and that help in the postpartum period will be proferred. Rural mothers tended to introduce home-cooked solid foods post-natally while urban mothers tended to use ready-made baby food products. In

addition, urban mothers tended to read more about pregnancy, birth and babies than their rural counterparts.

Table 10
Urban-Rural Differences

- Special qualities of blood lost in birth
- Witchcraft occurs in hospitals and clinics
- Pain should not be expressed in labour
- Husbands should be excluded in the post-partum period
- Reading about pregnancy, birth, babies
- Colostrum is good for the baby
- Sagging breasts desirable
- Type of solid introduced
- Post-partum help anticipated

DISCUSSION: LESSONS TO BE LEARNED A number of lessons regarding cross-cultural research are to be learned from the present study. Firstly the need to be aware of assumptions of the researcher that might possibly cloud the quality of the research was clearly illustrated by questions relating to sagging breasts following breast feeding, and the value of colostrum. Secondly, the need to examine the alternate culture without, as far as is possible, imposing the values of the researcher's own culture is highlighted. The role of the husband in birth encouraged by most 'Western' cultures and opposed by the Black culture needs to be respected, for instance. Thirdly, the need to assume the stance that the researcher's own culture is merely different from the other, but not always better than the alternate culture is essential. Only then can the meaning of certain customs (such as burial of the placenta, etc.) be viewed within their cultural structure, and understood. Fourthly, it is possible that in the Black culture at least, what is needed is a closer integration of first world medical practices and traditional customs. While traditional customs appear to be almost forgotten in the urban sample, these have not yet been adequately replaced by an understanding of first world medical procedures. At the same time rural women show a stronger adherence to some traditional customs which need to be incorporated into first world medical approaches. A mixture of first world and traditional approaches regarding childbirth may well be appropriate and indeed appear to be practiced in some situations. The final lesson to be learned from the present study concerns the meaning of the term "cross-cultural research". As can be seen, within the Black culture there are an infinite range of birthing experiences, from traditional rural home births attended by a traditional birth attendant, through clinic births, to hospital births with varying degrees of first world medical technological assistance. In some places too a mixture of traditional and 'Western' type birth situations are occurring. Amongst white women in Southern Africa too a similar range of birth experiences occur: women may deliver at home, in hospitals, or clinics. They may experience Odent style 'active births'; Leboyer type birth situations; technologically assisted births such as caesarean sections with general anesthetic; epidural vaginal births; births with or without analgesia; birth under hypnosis and even birth under water in alternate birth centres. It therefore seems extremely difficult to describe the Southern African culture as adopting any 'one' birth approach. Other parts of the world appear also to experience fairly wide variations in birth practices. These variations give rise to difficulties in characterizing a uniform type of birth in any one culture. Rather than continue to conduct cross-cultural research aimed at exploring differences in birth technologies in different cultures or countries it is suggested that attention be given to determining (a) what is common in all cultures with regard to birth, and (b) what is unique. Preliminary thinking along these lines suggests that there are a number of needs surrounding birth that are common to all cultures. These are physical, safety, emotional, intellectual, social and spiritual needs. However, how each of these needs is met will depend on the culture (or sub-culture) within which the birth occurs. For instance, the physical process of birth is similar for all women, but this may be influenced by variations in birth position or technology available in any particular culture. Safety needs too are common-women seek a safe environment for birth. But what is regarded as safe or where the woman/couple feel safe varies from home to hospital to alternate birth centres, etc. Emotional needs are also

vital for all women. However, the feeling that is desired varies amongst cultures. Some women look to birth as a time of emotional fulfillment, or sharing and love, while others may view the experience as a test of endurance or with a need to escape (for example by means of a general anesthetic). Intellectual understanding is also usually sought about pregnancy and birth events. The level of understanding will however vary according to the knowledge available in the community. For example, where ultra sound or alternate technology is possible, an infant's sex may be fairly accurately ascertained. Where technology is not available women will continue to attempt to predict their infant's gender on the basis of 'superstitious' beliefs such as 'the way the woman carries'. Social needs also appear to be common to most women at the time of birth. However cultures differ as to who is the ideal delivery assistant, birth companion, or source of ante- and post-partum assistance. Finally, spiritual needs are not often overtly acknowledged in writings about childbirth. However many cultures invoke spiritual aid of one form or another during pregnancy and birth. In some cultures this takes the form of prayers to an almighty power while in others it may manifest as a custom designed to appease the spirits. Perhaps if researchers were to acknowledge the universal needs of women in pregnancy and birth the primary objectives that need to be achieved in these situations would be clarified. In this way professionals assisting the pregnant woman may feel more free to explore the many alternatives in childbearing procedures that exist so as to best meet these objectives within the confines of the culture in which the birth occurs. References REFERENCE NOTES 1. Brindley, M. Old women in Zulu culture: The old woman and childbirth. S.Afr. J. Ethnol., 8 (1985) 98-108. 2. Gumede, M.V. Traditional Zulu practitioners and obstetric medicine. S.Afr. Med. J., 53 (1978) 823-827. 3. Larsen, J.V., Msane, C.L. and Monkhe, M.C. The Zulu traditional birth attendant. S.Afr. Med. J., 63 (1983) 540-542. 4. Chalmers, B. African Birth: Childbirth in Cultural Transition. Berev Publications, Sandton, 1990. 5. Chalmers, B. Pregnancy and Parenthood: Heaven or Hell. Berev Publications, Sandton, 1990. AuthorAffiliation Beverley Chalmers, Ph.D. AuthorAffiliation Dr. Beverley Chalmers is a professor of psychology at the School of Psychology, University of the Witwatersrand, Jan Smuts Avenue, Johannesburg, South Africa. She researches the psychosocial aspects of pregnancy, childbirth and the early stages of parenthood. She is particularly interested in the cross-cultural issues in this field. She is the author of Pregnancy and Parenthood: Heaven or Hell (1984) and African Birth: Childbirth in Cultural Transition (1990). She has also, together with G.J. Hofmeyr, produced a video entitled "Miscarriage: A Crisis Discarded" (University of Witwatersrand, CTV Services, 1989). This article is based upon a paper given at the International Conference on Childbearing and Perinatal Care, Jerusalem, in 1987, and was published as a pamphlet by The Institute for the Study of Man in Africa in 1987.

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